Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003915	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN PARK ASSISTED LIVING COMMUNITY	5045 WEST 52ND STREET INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00086797. Complaint IN00086797 - Unsubstantiated, due to lack of evidence. Survey Date: 3/14/11 Facility number: 003915 Provider number: 003915 AIM number: N/A Survey Team: Leia Alley, RN Census bed type: Residential: 45 Total: 45 Census payor type: Other: 45 Total: 45 Sample: 03 Autumn Park Assisted Living Community was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00086797. Quality review 3/18/11 by Suzanne Williams, RN	R 000		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE